7.05 continued

4. The Commissioner will issue the final decision of the Department subject to judicial review under M.G.L. c. 30A, § 14.

7.06: Criteria for Acquisition and Verification of Financial Information from Patients or Patient Guarantors

(1) General.

(a) 117 CMR 7.06 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the acquisition and verification of financial information from the patient and/or the patient guarantor in order to assess the ability of the patient or the patient guarantor to pay for hospital services.

(b) The Credit and Collection Policy shall specify the procedures for obtaining patient financial information; the procedures for obtaining verification of any existing foreign health insurance coverage, including foreign governmental health care coverage; the procedures for obtaining verification of any motor vehicle liability policy; the procedures for verifying patient supplied information; and the projected completion time for the verification activities.

(2) Minimum Requirements for Patient Supplied Information. The patient supplied information shall include, but shall not be limited to, the patient's name and address, the guarantor's (if any) name and address, the source of any available payment and the amount of such payment.

(3) Inpatient Services.

(a) Non-Emergency Admissions. The hospital shall make reasonable efforts, prior to the date of the patient admission, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Admission. The hospital shall make reasonable efforts, after the patient is admitted and as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(c) Requirements for Obtaining Additional Information During the Patient's Hospital Stay.

1. The hospital shall make reasonable efforts to contact the relatives, friends and guarantor and the patient for additional information while the patient is in the hospital.

2. The hospital shall identify the department that is responsible for obtaining the information from the patient, and explain the clinical approval process, if any, required in contacting the patient for additional information. If no clinical approval process is required prior to contacting patients, the Credit and Collection Policy must so specify.

(d) Requirements for Obtaining Information at the Time of the Patient's Discharge. If a hospital has not obtained sufficient patient financial information to assess the ability of the patient or the patient guarantor to pay for hospital services prior to the date of discharge, the hospital shall attempt to obtain the necessary information at the time of the patient's discharge.

(4) Outpatient Services.

(a) Non-Emergency Service. The hospital shall make reasonable efforts, prior to treatment, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(b) Emergency Service. The hospital shall make reasonable effort, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor.

(5) Verification of Patient Supplied Information.

(a) Inpatient. The hospital shall make reasonable efforts to verify the patient supplied information prior to the patient discharge. However, the verification may occur at any time during the provision of services, or at the time of the patient discharge or during the collection process.

(b) Outpatient. The hospital shall make reasonable efforts to verify patient supplied information at the time the patient receives the services. The verification of patient supplied information may occur at the time the patient receives the services or during the collection process.

7.07: Criteria for Assisting Patients Who Have Limited Financial Resources

117 CMR 7.07 specifies the criteria that a hospital's Credit and Collection Policy must meet regarding the assistance of patients and/or patient guarantors with limited financial resources.

(1) Deposit Plan.

(a) The hospital shall not require pre-admission and/or pretreatment deposits for patients who require emergency services.

(b) The hospital shall not require pre-admission and/or pretreatment deposits for patients with family income equal to or less than 200% of the Federal Poverty Income Guidelines.

(c) If hospitals require a pre-admission and/or pretreatment deposit for patients other than those described in 117 CMR 7.07(1)(a) and (b), the Credit and Collection Policy shall describe the method the hospital uses for establishing the amount of the deposit, and the document(s) required to verify the patient supplied information.

(2) Payment Plan.

(a) The hospital shall not require any payment plan for patients who are fully exempt from collection action pursuant to 117 CMR 7.08.

(b) A hospital's Credit and Collection Policy shall specify the hospital's policy regarding payment plans, including the methods for establishing patient liability, the information required from patients to establish payment ability, and the procedures used and the document(s) required to verify the patient supplied information.

(3) Deferred or Rejected Admissions.

(a) A hospital shall not defer or reject admission of patients who are recipients of governmental benefits under M.G.L. c. 117A *et seq.* (EAEDC) solely due to financial considerations.

(b) If a hospital wishes to defer or reject admission of other patients solely due to financial considerations, its Credit and Collection Policy shall specify the policies and procedures used for such decisions. In all instances, the reasons for deferral or rejection, and the clinical approval or acknowledgement of such deferral or rejection shall be documented.

7.08: Criteria for Identification of Populations not Requiring Collection Action

117 CMR 7.08 specifies the criteria for identifying those populations which shall not be subject to collection action as defined pursuant to 117 CMR 7.02. by setting a minimum free care eligibility standard. 117 CMR 7.08 also governs the criteria the Credit and Collection Policy must meet regarding the determination of patients exempt from collection action.

(1) General Requirements.

(a) All free care provided shall be accompanied by an application for free care signed by the patient, relative or legal guardian. Each application for free care must state, in part, the following:--"I authorize you to release any information acquired in the course of my examination or treatment to the Department of Medical Security or its designee."

(b) There shall be no residency requirements for patients who are residents of the Commonwealth of Massachusetts. If a hospital does not have such requirements for out of state patients the Credit and Collection Policy must so specify.

(c) The hospital or its agent shall not seek legal execution against the personal residence or automobile of patients or guarantors with family income in excess of 200% of the Federal Poverty Income Guidelines, without the express approval of the hospital's Board of Trustees on an individual case by case basis.

(d) The hospital shall not bill patients who are recipients of governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, certain participants of the Department's Children's Medical Security Plan, or the participants in the Department of Public Health's Healthy Start program or of the Department's CenterCare program. The Department shall issue periodic notices to the hospitals regarding billing of the participants in the Children's Medical Security Plan. However, the hospital may initiate billing for a patient who alleges that he or she is a participant in any of the programs listed in 117 CMR 7.08(1)(d), but fails to provide proof of such participation. Upon receipt of a satisfactory proof that a patient is a participant in any of the above listed programs, the hospital shall cease its collection activities.

7.08: continued

(e) A patient who applies for free hospital services must receive a written notice of the hospital's decision within a month of completion of a written application and submission of the required information.

(f) Once a hospital determines a patient to be eligible for free care hospital services the hospital may determine the patient to be eligible for such services for six months from the date of the initial determination.

(g) A hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age for persons beyond the age of majority, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or eligibility for free care.

(h) Any patient who is determined eligible for partial free care under 117 CMR 7.08(2)(c) and has a patient balance of $500 or more shall be offered in writing a payment plan of at least two years. A hospital may initiate any collection actions allowed under its Credit and Collection Policy for overdue payments, and may write-off overdue amounts as bad debt consistent with its Credit and Collection Policy. Nothing in 117 CMR 7.00 shall prohibit hospitals from assessing interest under such payment plans.

(2) Standards for Exemption of Patients from Collection Action.

(a) Recipients of governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, certain participants of the Department's Children's Medical Security Plan, or the participants in the Department of Public Health's Healthy Start program or of the Department's CenterCare program shall be exempt from collection action. The Department shall issue periodic notices to the hospitals regarding collection actions affecting the participants in the Children's Medical Security Plan.

(b) If a hospital provides inpatient or outpatient services to a person whose family income is equal to or less than 200% of the Federal Poverty Income Guidelines, such person shall be exempt from collection action.

(c) If a hospital provides inpatient or outpatient services to a person whose family income is between 200% and 400% of the Federal Poverty Income Guidelines, such person shall be exempt from collection action for the portion of his/her hospital bill that exceeds 40% of the amount by which the patient's family income exceeds 200% of the Federal Poverty Income Guidelines for the patient's family size.

(d) If a hospital provides inpatient or outpatient services to a person whose family income is greater than or equal to 200% of the Federal Poverty Income Guidelines, the hospital shall exempt such person from collection actions with respect to all or part of the amount billed to the patient if the patient or guarantor is deemed to be financially unable to pay for the patient's hospital care due to medical hardship as determined pursuant to 117 CMR 7.08(3).

(3) Requirements Regarding Determination of Income, Family, Size and Medical Hardship.

(a) A hospital's Credit and Collection Policy shall specify the criteria and procedures that the hospital uses to determine whether a person shall be exempt from collection action under 117 CMR 7.08(2) for all or part of the bill. The Credit and Collection Policy shall distinguish, where relevant, between free care provided pursuant to 117 CMR 7.08(2)(a) through (c) and medical hardship provided pursuant to 117 CMR 7.08(2)(d). At a minimum, the Credit and Collection Policy shall:

1. Specify any forms or applications used to determine free care or medical hardship under 117 CMR 7.08(2);
2. Describe the procedures to be used in making the determinations required under 117 CMR 7.08(2), including any sliding scales used to measure the relationships between income, health care and insurance costs, and length of payment schedule; and
3. State who in the hospital is responsible for making decisions regarding eligibility for free care or medical hardship under 117 CMR 7.08(2)(d).

(b) When specifying the criteria and procedures that a hospital uses to determine medical hardship pursuant to 117 CMR 7.08(2)(d), the hospital's Credit and Collection Policy must, at a minimum, address whether it considers the following factors, and if so how:

1. The amount of the patient's family income -- adjusted for extraordinary expenses (such as high child care or parent costs) -- relative to the amount of his/her health care expenses and health insurance premium costs;
2. The existence and availability of family assets;

7.08: continued

3. The patient's future income earning capacity, especially where the patient's ability to work in the future may be limited as a result of illness; and
4. The patient's ability to make payments over an extended period of time.

7.09: Criteria for Notification of the Availability of Free Care to Patients

117 CMR 7.09 specifies the criteria that hospitals must meet regarding notification of the availability of free care and/or public assistance programs to patients. Hospitals shall employ the following procedures to notify patients of the availability of free care and to assist patients for possible eligibility for public assistance programs.

(1) Notification.

(a) Posting. The hospital shall post signs, in the inpatient, outpatient and emergency admissions/registration areas and in business office areas that are customarily used by patients, that conspicuously inform patients of the availability of free care and where to apply for such are. Such signs shall be in large print.

(b) Individual Notice. A hospital shall provide individual notice of availability of free care where a hospital has been given an indication that a patient will incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage. The individual notice shall specify the income and resource criteria the hospital uses in order to determine patient eligibility for free care, and the time it takes the hospital to make such a determination and include also information where patients can apply for free care. A copy of such notice must be included in the hospital's Credit and Collection Policy.

(c) A hospital shall include a notice of free care as described in 117 CMR 7.09(1)(b) in its initial bill. In all other written collection action the hospital shall include a brief message of the availability of free care and other types of assistance and what telephone numbers to call for more information.

(d) All signs and notices specified in 117 CMR 7.09(a), (b) and (c) shall be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the hospital's service area.

(2) Assistance. The hospital shall advise and assist patients concerning the patient's possible eligibility for public assistance programs. The policy and procedures for advising such patients shall include, at a minimum, the provision to patients of information concerning the availability of Medical Assistance Programs and the distribution of brochures for public assistance programs and the local legal services, if such brochures are made available to the hospital by Medicaid and the local legal services agency.

7.10: Documentation and Audit: Free Care Accounts

(1) Each hospital shall maintain auditable records of its activities made in compliance with the criteria and requirements of regulation 117 CMR 7.00. The hospital's free care write-offs as reported on RSC-404, RSC-403, DMS Form UC-92, DMS Form UC-93 or any successor form, that has been filed, shall be documented. Each hospital's free care write-offs, shall be accompanied, at a minimum, by documentation of all efforts made by the hospital to determine free care eligibility.

(2) Documentation for free care accounts to verify family income, may cover a period from one to six months. Acceptable forms of documentation may include, but are not limited to, the following:

(a) a written, notarized, signed statement from the patient's employer;
(b) W-2 forms;
(c) pay check stubs;
(d) copies of payment checks;
(e) tax returns;
(f) bank statements;
(g) accounting records;
(h) benefit award letters;
(i) social security benefit statements;
(j) retirement refund documents;

7.10 continued

(k) court payment records; and
(l) broker statements.

A detailed description of a hospital's income information documentation process should appear in its Credit and Collection Policy.

(3) Income Documentation for Patients Without Resources. Should a patient report that there is no current source of family income and that no prior income information is available, a sworn, signed free care application and a brief statement describing how the patient is being supported may be considered sufficient documentation for audit. A detailed description of documentation requirements for patients without financial resources should appear in a hospital's Credit and Collection Policy. The hospital official responsible for determining eligibility under 117 CMR 7.10(3) must attempt to verify whether a free care applicant is currently receiving medical assistance from other governmental sources. In addition, the hospital official should inform the applicant that medical assistance through other governmental sources may be available.

(4) If a hospital fails to meet the requirements of 117 CMR 7.00, the Department may adjust the hospital's payments from the uncompensated care pool.

(5) The Department's audit procedures regarding free care accounts and the Department's schedule of audit adjustments regarding deficiencies in documentation shall be detailed in a separate administrative information bulletin issued pursuant to 117 CMR 7.12. The audit adjustments will reflect the degree of non-compliance with the Department's criteria for documentation of free care accounts.

7.11: Utilization Review

(1) In order to encourage maximum efficiency and appropriateness in the utilization of acute hospital services there shall be an utilization review for hospital admissions and continued acute hospital stays.

(2) The utilization review may be conducted by the Department or its designee.

(3) Nothing set forth in 117 CMR 7.11 shall be construed as affecting the calculations of payments to and from the pool as otherwise provided for in 117 CMR 7.04.

(4) Utilization review shall be conducted for those hospital admissions and continued acute hospital stays which are included in the calculation of the gross liability of a hospital from the uncompensated care pool. An utilization review shall not be conducted in those instances where another third party payer has conducted an utilization review.

(5) Utilization review shall be administered and conducted as set forth in the "Provider Reference Guide" which is incorporated herein by reference. All terms and conditions set forth in the "Provider Reference Guide" shall have the same force and effect as if fully set forth herein. All changes or amendments to the "Provider Reference Guide" shall be governed by the same procedural requirements as are 117 CMR. The effective date of 117 CMR 7.00 set forth in 117 CMR 7.01(1)(c)5. shall be construed consistently with and effectuating the dates set forth in the "Provider Reference Guide."

(6) Upon exhaustion of appeal of a review determination described in the "Provider Reference Guide" a hospital may seek an administrative review by the Department. The procedure of such administrative review by the Department shall be governed by 117 CMR 7.05(2) and (3). Such procedure shall be adopted, as appropriate to the unique requirements of the utilization review program.

7.12: Administrative Information Bulletins

The Department may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 117 CMR 7.00. In addition, the Department may issue administrative information bulletins which specify the information and documentation necessary to implement 117 CMR 7.00.

7.13: Severability

The provisions of 117 CMR 7.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 117 CMR 7.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

REGULATORY AUTHORITY

117 CMR 7.00: M.G.L. c. 118F, §§ 6(a) and 15 as amended by St. 1995, c. 38.